

AUM Student Health Services

Name Drann Mitchell Date of Birth 06 Dec 72

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (valve, vessel, rheumatic, etc.) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (other than glasses or contacts) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever	Stomach/Bowel ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease Neurological ☒ Concussions (1) 2005 ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA Mental Health ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (Eating Disorder) ☐ Anxiety Disorder ☐ Bulimia (Eating Disorder) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy Orthopedics ☒ Arthritis ☐ Fractures/Broken Bones Infectious Diseases ☒ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever Skin ☐ Eczema ☐ Psoriasis ☐ Hives	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholinesterase Deficiency ☐ Spinal headache Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair ☐ Knee Arthroscopy ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD OB/GYN History ☐ Endometriosis ☐ Pregnancies #: <u>0</u> Exercise History ☒ Lack of exercise ☐ Exercising regularly Moderate Exercising Walking briskly, water aerobics, etc. ☐ Less than 3 times per week ☐ 3 or more times per week Strenuous Exercising Running, swimming laps, etc. ☐ Less than 3 times per week ☐ 3 or more times per week
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☐ NO Significant Health Problems

List Medications

Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ No

Medication Allergies: NONE

Food Allergies: NONE

Other Allergies (latex, bee stings, etc.): NONE

Other History

☐ Previous Hospitalizations NONE

☐ OTHER Health Problems

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism	N/A	✓		
Blood Clots/Clotting Disorders				
Cancer				
Breast	N/A	N/A	N/A	N/A
Colon	N/A	N/A	N/A	N/A
Melanoma	N/A	N/A	N/A	N/A
Other Cancers (List Type)	N/A	N/A	N/A	N/A
Diabetes				
Drug Dependency	N/A	N/A	N/A	N/A
Heart Disease				
High Blood Pressure	✓	N/A	✓	N/A
High Cholesterol				
Mental Illness	N/A	✓	✓	N/A
Stroke				
Sudden Cardiac Arrest (under age 50)	N/A	N/A	N/A	N/A
Other (Please explain)				
Parent Deceased	✓ 1992	✓ 1984		

What is your gender?

- ☒ Female
☐ Male
☐ Transgender
☐ Other

What is your sexual orientation?

- ☒ Heterosexual (Straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other

Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No
Physical Abuse ☐ Yes ☒ No
Sexual Abuse ☐ Yes ☒ No

Drug History

Do you take recreational drugs? ☐ Yes ☒ No

How much? _____ How often? _____ What type? Marijuana Cocaine Meth Heroin Spice Other _____

Sexual History

Sexually active? ☒ Yes ☐ No ☐ Not currently

Partners ☒ Male ☐ Female ☐ Both

Birth Control/Protection - Please circle: Tubal ligation

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other see comments None

Last Menstrual Cycle 11 Dec 17 Last PAP 2014 Normal Abnormal (Circle)

Comments:

Tobacco Use History

- ☐ Current every day
☐ Current some days
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☒ Never smoker
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 2 4 5 10

Alcohol Use History

- ☐ Current every day
☐ Current some days
☐ Former drinker
☐ Heavy drinker
☐ Social drinker
☒ Never drinks

Please circle:

Type used: Beer Wine Liquor

Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 2 4 5 10